Community Consumer Submission 3 Frequently Asked Questions: No. 1

The Virginia Association of Community Services Boards (VACSB) Data Management Committee (DMC) and the Department of Mental Health, Mental Retardation and Substance Abuse Services (Department) periodically will distribute Frequently Asked Questions (FAQs) and answers to assist community services boards and behavioral health authorities, hereinafter referred to as CSBs, and their information system vendors as they implement the Community Consumer Submission 3 (CCS 3). FAQ answers will become part of CCS 3 business rules, as appropriate, when the rules are distributed. If you have any questions about these FAQs or want to ask additional questions, please contact Fred Mitchell, the DMC Chairman, at fmitchell@colonialcsb.org or Paul Gilding, the Department's Community Contracting Director, at paul.gilding@co.dmhmrsas.virginia.gov.

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Community Consumer Submission 3 Frequently Asked Questions: No. 1

Implementation Questions

1. *What was the mindset behind the rollout timeframe for CCS 3? It seems too short.*

   ANSWER: The timeframe is essentially the same as the one used to implement CCS 2, which contained more data element changes. Also, the VACSB DMC and the Department have been working intensively on CCS 3 since the spring of 2006. Finally, the VACSB DMC and the Department issued a memo, dated March 9, 2007, that clarifies some of the implementation dates in earlier communications.

2. *Can CSBs implement CCS 3 over a longer timeframe than July 1, 2007?*

   ANSWER: CSBs must implement the CCS 3 extract specifications and be able to comply with CCS 3 reporting requirements, starting on July 1 for FY 2008 and subsequent fiscal years, so that CSBs and the Department can meet existing federal reporting requirements and improve the quality and completeness of CCS data. However, CSBs can implement some aspects of the New CCS Admission and Discharge Paradigm, in terms of local clinical or service delivery practices and information system procedures, over a longer timeframe than July 1, 2007.

3. *Does this change (New Paradigm) require a modification of CSB information systems?*

   ANSWER: Most information system modifications would depend on the extent to which a CSB chooses to implement the New CCS Admission and Discharge Paradigm in FY 2008. The only thing that a CSB must do is make any needed changes in its local processes or procedures to ensure that it can comply with CCS 3 extract specifications and reporting requirements. This may be accomplished by conversion routines in CSB information systems or local CCS 3 extracts. Please note that the final version of the New Paradigm is dated February 2, 2007; earlier versions should be discarded to avoid confusion.

4. *Will there be any funds to support implementing the case opening paradigm (actually CCS 3)?*

   ANSWER: Several sources of funds exist to support the implementation of CCS 3. CSBs should continue to use existing state funds that the Department has provided on an ongoing basis in the past, such as the $40,000 of federal mental health block grant funds that are part of CSB funding bases, to support CCS implementation. CSBs also should use their pools of unobligated balances of unexpended funds from previous fiscal years, if these exist, to implement CCS 3 changes. Finally, the Department has provided $42,500 of one-time federal mental health block grant funds in FY 2007, part or all of which can be used to support implementation of CCS 3. Finally, at least one of the main CSB information system vendors has indicated its commitment to implement CCS 3 at no cost to its customers.

5. *How will the transition from CCS 2 to CCS 3 be handled for mental health Early Intervention Services?*

   ANSWER: CCS 3 identifies Early Intervention Services as a Service Available Outside of a Program Area, and data about these services will be extracted using the 400 code. However, to provide as much operational flexibility as possible in CCS 3, a CSB could still identify Early Intervention Services as mental health, mental retardation, or substance abuse services, if it desires to do so; but its information system or CCS 3 extract must convert the local mental health (100), mental retardation (200), or substance abuse (300) Program Area identification code into the 400 code (Services Available Outside of a Program Area) in its CCS 3 submissions.

Additionally, the Department will modify the FY 2008 Performance Contract and CARS reporting software to include another page in Exhibit A. Along with Forms 11, 21, and 31 for the Services Available at Admission to a Program Area, there will be a fourth form, Form 01: Services Available Outside of a Program Area, where CSBs will display information about Emergency Services, Motivational Treatment Services, Consumer Monitoring Services, Assessment and Evaluation Services, Early Intervention Services, and Consumer-Run Services, which do not have a Program Area identification, per the Core Services Category and Subcategory Matrix on page 16 of Core Services Taxonomy 7.1.

6. *Will existing CCS 2 program enrollments be collapsed into program admission records?*

ANSWER: CCS 3 eliminates enrollments in and releases from each individual core service in each Program Area; this can significantly reduce paperwork and workload for direct service staff. Instead, CSBs are only required to admit consumers to and discharge consumers from each Program Area in which they receive services. However, to provide as much operational flexibility as possible in CCS 3, CSBs may continue to enroll and release consumers in and from individual core services at the local level if they want to perform that additional work. If it chooses to continue this practice, a CSB must convert those enrollments and releases to admissions and discharges. The CSB's information system or CCS 3 extract must convert the first enrollment to any service, defined in CCS 3 as a Service Available at Admission to a Program Area, in a Program Area into the Program Area admission and convert the last release from any service, defined in CCS 3 as a Service Available at Admission to a Program Area, in that Program Area into the Program Area discharge. Services that are Services Available Outside of a Program Area are not converted to a Program Area admission or discharge. For example if a consumer received only emergency services in FY 2007, no admission would be created for this consumer in a TypeOfCare.txt file, only a Consumer.txt file, if one already did not exist. Also, see answer 8.

7. *Can CSBs still admit consumers to limited services?*

ANSWER: In CCS 2, admission is to the CSB, not to a particular category (e.g., Limited Services) or subcategory (e.g., Consumer Monitoring) of core services. A CSB enrolls a consumer in any service with a Service Code. In CCS 3, admission is to a Program Area, not to the CSB, and there are no enrollments to and releases from core services. Because Limited Services are Services Outside of a Program Area, consumers are not admitted to them in CCS 3. A consumer's receipt of these services would be reported in a Service.txt record with the 400 code instead of a Program Area Code and no TypeOfCare.txt record would be submitted. However, to provide as much local operational flexibility as possible in CCS 3, a CSB could admit a consumer to any level (the CSB, a Program Area, or a core services category or subcategory) as long as it converts whatever it considers to be an admission to a Program Area admission, as defined in Core Services Taxonomy 7.1 and CCS 3, in the CCS 3 extracts that it submits to the Department. Also, see answer 8.

8. *How should CSBs report on consumers who were admitted to the CSB before July 1, 2007, since after that date, admission is to a Program Area, rather than to the CSB?*

ANSWER: For each currently active consumer, each CSB needs to convert, for the applicable Program Area, the first enrollment in a Program Area service associated with the most recent admission to the CSB in FY 2007 or a previous fiscal year to the applicable Program Area admission (TypeOfCare.txt file) for CCS 3. When a consumer was enrolled in services in more

than one Program Area during the current admission to the CSB, a Program Area admission needs to be created using this process for each Program Area. Before July 1, 2007, if a consumer was not enrolled in a service categorized in CCS 3 as Services Available at Admission to a Program Area, but was enrolled only in a service categorized in CCS 3 as Services Outside of a Program Area, no CCS 3 Program Area admission should be created, only a CCS 3 Consumer.txt file, if one does not exist.

9. *How does the New CCS Admission and Discharge Paradigm reflect dually diagnosed services or the COSIG initiative?*

   ANSWER: The New Paradigm only provides the conceptual framework for the CCS 3 and Taxonomy 7.1. CCS 3 and Taxonomy 7.1 reflect a gradual adaptation and implementation of the integrated services and co-occurring disorders framework in the COSIG initiative, through capturing more complete diagnostic information and by shifting admission and discharge tracking from the CSB level to the Program Area level. Co-occurring disorders are defined in Taxonomy 7.1, and CCS 3 provides data through which individuals with co-occurring disorders can be identified and tracked, including the services that they receive. However, the New CCS Admission and Discharge Paradigm, Core Services Taxonomy 7.1, and CCS 3 do not define or identify dually diagnosed services.

10. *How will the transition from CCS 2 to CCS 3 be handled, including the final (4th quarter) CARS and CCS 2 reports?*

    ANSWER: The VACSB DMC and the Department issued a memo, dated March 9, 2007, on the final FY 2007 reports and implementing CCS 3 in FY 2008, and CSBs and the Department should follow the schedules in that memo. Final FY 2007 CCS 2 reports will be due by August 29, and any corrections of CCS 2 data must be submitted no later than October 1. CCS 3 submissions (Consumer.txt, TypeOfCare.txt, and Service.txt files) for the first four months of FY 2008 will be due by November 28, 2007.

11. *In CCS 3, how do CSBs pull the correct code and connect the diagnosis with a program enrollment?*

    ANSWER: There are no program enrollments in CCS 3. If the CSB opens a case on a consumer and provides any of the Services Available Outside of a Program Area, the CSB determines the diagnosis whenever possible and reports that in the Consumer.txt file. When the CSB admits a consumer to a Program Area directly or after Case Opening, it collects and reports diagnoses, if this data has not already been collected and reported in the Consumer.txt file.

12. *Do CSBs need to examine and possibly change their billing and business processes and other practices as part of implementing CCS 3?*

    ANSWER: Each CSB may need to do this, but all of this does not have to be done before or by July 1, 2007, unless the CSB decides to do so. At a minimum, the CSB must analyze the CCS 3 extract specifications and determine what processes need to be modified or developed to comply with them. For instance, a CSB may decide to continue enrolling and releasing consumers in and from individual core services, but it must figure out how to convert this information into the Program Area admission and discharge structure that is an integral part of CCS 3.

13. *Will the CCS 3 extract software provided by the Department contain error checking routines and standardized formatted reports, like those in CCS 2?*

    ANSWER: Yes, the CCS 3 extract software provided by the Department will contain error-checking routines, produce error reports, and include standardized formatted reports, like the CCS 2 software did. However, each CSB should require its information system vendor to build in as much error checking as possible into its local information system to ensure that the system produces the most error-free data possible for the CSB's use and submit through CCS 3. Each CSB is responsible for the quality of the data that it extracts and submits through CCS 3; the Department is providing error-checking routines to assist CSBs, but these routines do not replace the need for adequate internal error checking functionality in CSB information systems.

14. *Can CSBs have some more brainstorming meetings like the January 29 orientation and training event?*

    ANSWER: Based on feedback to the VACSB DMC, additional meetings may be offered. Hopefully, these FAQs will address this need to some extent.

Consumer.txt Questions

15. *CCS 3 requires reporting diagnoses for Services Available Outside of a Program Area (Case Opening), but CSBs are unlikely to have a diagnosis at case opening unless a full assessment is done on the consumer. Do CSBs still have to report diagnoses for these services?*

    ANSWER: CSBs must report diagnoses for consumers receiving any Services Outside of a Program Area if that information is available, initially or at subsequent contacts with the consumer. Services Outside of a Program Area services are: Emergency, Motivational Treatment, Consumer Monitoring, Assessment and Evaluation, Early Intervention, and Consumer-Run Services. Clearly, Emergency Services is the service in which a diagnosis is most important. In CCS 2, CSBs are required to report diagnoses for Emergency Services. Most CSBs do not perform a full assessment before admitting the consumer and enrolling him or her in Emergency Services. Diagnoses are often assigned on a preliminary basis pending a more complete assessment at a later date. Reporting diagnoses for consumers receiving Emergency Services will continue in CCS 3. If diagnoses are available for other services in Services Available Outside of a Program Area, staff should enter them in the CSB's information system, where CCS 3 can extract them.

16. *What data elements are required for Services Outside of a Program Area in CCS 3?*

    ANSWER: All of the data elements identified in the table on page 41 (data elements collected at case opening) in the CCS 3 Extract Specifications are required to be reported, if they are available.

17. *Are HMOs included in addition to Medicaid?*

    ANSWER: Health maintenance organizations (HMOs) are one type of organization that provides Medicaid-reimbursed services. If this is a question about CCS 3 data element 57 (Medicaid No.), if a consumer is enrolled in Medicaid, regardless of whether he or she receives Medicaid-reimbursed services from an HMO or other managed care organization, a private practitioner or agency, or a CSB, his or her Medicaid number must be reported through CCS 3. HMOs are not a separate reimbursable funding stream, like Medicaid fees; they are providers that use Medicaid reimbursements to provide services to Medicaid-enrolled individuals.

18. *Medicaid number (MedicaidNbr - data element 57) is a new data element in CCS 3; it replaces Medicaid Status in CCS 2. CCS 3 Extract Specifications indicate that it has a maximum length of 12 characters. If Medicaid numbers in a CSB's information system include hyphens that make numbers longer than 12 characters, how should they be entered in the Consumer.txt file?*

    ANSWER: If there are any hyphens in a Medicaid number locally, they must be stripped before entering Medicaid numbers in CCS 3. The Department of Medical Assistance Services (DMAS) prescribes the format of this number as a 12 digit numeric field, with leading zeros as needed to fill the field. Accordingly, CCS 3 standardized on this DMAS format. As with most CCS3 data extract fields, formatting characters like hyphens (-) and pound signs (#) should be stripped out if they exist in a CSB's source systems. So a 15 character Medicaid number field (12 numbers plus 3 dashes) must have the dashes eliminated as part of the local process of creating the CSB's extract files.

    This data element is designed to carry the consumer's Medicaid number, if the consumer is currently enrolled or was ever enrolled in Medicaid during the current episode of care. Page 37 of the CCS3 Extract Specifications states, "if a consumer is enrolled in Medicaid at one point, but then loses his or her Medicaid eligibility, the value in this field should continue to show the Medicaid number. If the consumer's Medicaid number changes, then the new number must be transmitted." If a consumer is enrolled in Medicaid after he or she is admitted to a Program Area, the consumer's Medicaid number should be included in the Consumer.txt record submitted on that consumer in the month following his or her enrollment in Medicaid. This Medicaid number is the same number that the CSB uses for Medicaid billing currently.

19. *Will the Medicaid number be used to track spend down or revenues? Is it asking if a consumer ever was enrolled in Medicaid or only if this is now in the consumer's record?*

    ANSWER: The Medicaid number will not be used to track a consumer's spend-down status or revenues. Monitoring a consumer's eligibility for Medicaid is the consumer's case manager's responsibility, although the local Department of Social Services is actually responsible from the perspective of the Department of Medical Assistance Services (DMAS). This data element means did the consumer have a Medicaid number when he or she was admitted to a Program Area? This would apply at the most recent admission to a Program Area. Medicaid number is collected only at admission to a Program Area. The Medicaid number data element has no relationship to whether a consumer is currently receiving a Medicaid-reimbursed service; it only indicates that the consumer was enrolled in Medicaid when he or she was admitted to a Program Area.

20. *Are there any plans to encrypt the Medicaid number, like the Social Security Number, which is encrypted?*

    ANSWER: There is no plan to encrypt the Medicaid number; there is no requirement under the Health Insurance Portability and Accountability Act of 1986 (HIPAA) to encrypt it.

21. *When a consumer is placed in an orientation group, run by a clinician but not billed, to reduce the no-show rate for first appointments, and the consumer subsequently accepts an appointment in a service at a later date, how should the Days Waiting to Enter Treatment (CCS 3 data element 46) be calculated: the number of days from the first call for services to the first accepted orientation group appointment; from the first call to the first accepted intake appointment following the orientation appointment; or from the first call to the first accepted appointment in the initial service following the intake appointment?*

ANSWER: CCS 3 extract specifications for data element 46 define it as the number of calendar days from the first contact or request for service until the first scheduled appointment accepted by the consumer. The intent of this data element is to determine how long it takes individuals to begin receiving clinical services (treatment). Given the description in the question, the orientation group does not constitute treatment; it is described as a triage activity to determine if the individual is suitable for a particular program. Accordingly, for this question, days waiting to enter treatment should be calculated from the first call or request for services to the first scheduled appointment in a treatment service accepted by the individual.

22. *What constitutes an arrest for data element 47 (NbrOfArrests), the issuance of an arrest warrant or does the person have to be taken into custody?*

ANSWER: This data element is intended to capture the number of times a consumer was arrested for any cause during the 30 days preceding the date of admission to the mental health or substance abuse Program Area. CSBs should count any formal arrest, regardless of whether incarceration or conviction resulted and regardless of the status of the arrest proceedings on the date of admission.

TypeOfCare.txt Questions

23. *What is the purpose of the type of care (TypeOfCare.txt) file?*

ANSWER: The current purposes of the TypeOfCare file in CCS 3 are to identify: (1) a consumer's admission to and discharge from a Program Area, (2) the dates of the admission and discharge, (3) a consumer's entry into and exit from a specialized initiative or project using a Consumer Designation Code (see page 15 of Taxonomy 7.1), and (4) the dates of a consumer's entry into and exit from that specialized initiative or project. Core Services Taxonomy 7.1 defines an episode of care as all of the services provided to a consumer to address an identified condition or support need over a continuous period of time between an admission to and discharge from a Program Area. The TypeOfCare file combines two files from CCS 2: the Admission file and the Program file. In CCS 3, this file originally was named EpisodeOfCare, but CCS 3 also needs to capture Consumer Designation Codes (collected in CCS 2 in the Program file as program enrollments and releases), so the file name was changed to TypeOfCare to allow this additional information to be captured when applicable.

24. *Why was the period of time with no contact requiring the discharge of a consumer from a Program Area reduced from 180 to 90 days?*

ANSWER: The existing 180 day period in Taxonomy 7 was not reasonable or clinically appropriate, and the federal government has established an even shorter period (30 days) for discharging a consumer who has had no contact with the service. Changing the CCS 3 and Taxonomy 7.1 period from 180 to 90 days is more clinically appropriate and partially accommodates the even shorter federal period, which is probably too short.

25. *How should services provided to children and adolescents in juvenile detention centers be reported in CCS 3?*

ANSWER: Beginning on July 1, 2007, all CSBs providing mental health Case Management or Outpatient Services, formerly funded with federal funds from the Department of Criminal Justice Services and now funded with restricted mental health state general funds, must admit those consumers to the mental health Program Area and report all applicable CCS 3 data elements for those individuals.

A new Consumer Designation Code (916) is being added to CCS 3 to enable these individuals to be tracked. This may replace the current paper reporting mechanism maintained by the Department's Office of Mental Health Services.

26. *When should a child or adolescent receiving mental health services be given a Consumer Designation Code of 915 for the Mental Health Child and Adolescent Services Initiative (formerly the Non-CSA-Mandated Services Initiative)?*

ANSWER: A child or adolescent should be assigned the 915 Consumer Designation Code when he or she (1) has been admitted to the mental health Program Area, and (2) meets the diagnostic criteria for this designation (e.g., has serious emotional disturbance), and (3) is receiving services funded by this initiative. If the consumer meets the first two criteria, but not the third, he or she should not receive this Consumer Designation Code until he or she is receiving services funded by this initiative. Subsequent to receiving this designation, the consumer may receive other mental health services not funded by this initiative, which will be linked to this designation by the TypeOfCareFromDate and ThroughDate and the service dates in Service.txt files. For children and adolescents who received this designation prior to July 1, 2007 through a program enrollment in CCS 2, CSBs need to convert those enrollments into TypeOfCare.txt records for submission in CCS 3 after July 1, 2007.

When a child or adolescent with this Consumer Designation Code is discharged from the mental health Program Area, along with the TypeOfCare.txt record submitted to record the discharge, a second TypeOfCare.txt record, updating the related TypeOfCare.txt record submitted when the consumer received the designation, must be submitted ending this designation. Similarly, when a child or adolescent with a 915 Consumer Designation in FY 2007 ages out of this designation or no longer meets the diagnostic criteria in FY 2008, even if he or she remains admitted to the mental health Program Area and continues to receive other mental health services, an updated TypeOfCare.txt record must be submitted ending this designation.

27. *Will the Consumer Designation Code for the Medicaid Mental Retardation Home and Community-Based Waiver (920) be applied to the Mental Retardation Day Support Waiver?*

ANSWER: No, Consumer Designation Code 920 applies only to the Medicaid Mental Retardation Home and Community-Based Waiver. Adding a code for the Day Support Waiver was considered but rejected for implementation in Core Services Taxonomy 7.1. However, CSBs must include information about consumers, units of service, cost, revenues, and expenditures in their performance contracts and reports and in CCS 3, per subdivision 7 of subsection A of section 37.2-504 in the *Code of Virginia*, for consumers receiving services under the Medicaid Mental Retardation Day Support Waiver that are provided by CSBs directly or contractually.

28. *Has core service 930 been eliminated?*

ANSWER: Code 930 is not a core service; it was the CCS 900 Code for Substance Abuse State Facility Admission Diversion Projects in Core Services Taxonomy 7 and CCS 2. In Core Services Taxonomy 7.1 and CCS 3, this 930 code is eliminated from the list of Consumer Designation Codes, since it is no longer needed.

Service.txt Questions

29. *How will CSBs track Consumer-Run Services since consumers in those services are not admitted to a Program Area?*

    ANSWER: Consumer-Run Services are not traditional clinical or treatment services, and the nature and context of these programs emphasize consumer empowerment and provide support in an informal setting. See the definition for these services in Core Services Taxonomy 7.1. Also, the service model for Consumer-Run Services is still evolving. Consequently, no Service.txt records will be submitted for Consumer-Run Services. Also, no Consumer.txt records will be submitted for consumers who receive only Consumer-Run Services. Instead, a count of consumers receiving this service will be gathered manually and reported on Form 01 in CARS.

30. *What needs to be done about the end date (ServiceThroughDate) when the date will be left blank if a consumer is still receiving services at the end of a month?*

    ANSWER: The ServiceThroughDate at the end of the month should not be left blank. When provision of a service spans multiple months, it must be split into monthly service records. If a consumer continues to receive a service beyond the end of a month, the Service.txt file for that month would include a record with that date in the ServiceThroughDate, and the CSB would include a Service.txt record in the next monthly submission with a ServiceFromDate of the first day of the following month. CSBs need to report ServiceThroughDates whenever they are available, but only ServiceFromDates are required in the Service.txt file. The CCS 3 Extract Specifications states on page 7 that this date may be left blank if the CSB is not able to report it due to technical limitations in its information system. Otherwise, this date should be reported. The Department can use the service dates in subsequent monthly submissions of service data for the same consumer to determine that those consumers are still receiving services. When the consumer no longer receives the service, a ServiceThroughDate would be reported in the Service.txt file.

31. *In CCS 3, Emergency Services is moved to Services Available Outside of a Program Area, thus the services will have no Program Area identification. Isn't reporting substance abuse Emergency Services a Treatment Episode Data Set (TEDS, a federal substance abuse block grant reporting system) reporting requirement?*

    ANSWER: The federal government does not require reporting substance abuse Emergency Services through the TEDS, and the Department has never reported these services to the federal government. Therefore, lack of Program Area identification is not a problem for these services.

32. *If* a CSB *does not admit consumers to Emergency Services, will it lose counts for local purposes?*

    ANSWER: CSBs will still count and report on consumers receiving Emergency Services, but CCS 3 will not attach a Program Area identification code to those services. Instead, CCS 3 will identify Emergency Services as a Service Available Outside of a Program Area with the 400 code. However, to provide as much operational flexibility as possible in CCS 3, a CSB could still identify Emergency Services as mental health or substance abuse services if it desires to do so, but its information system or CCS 3 extract must convert the local mental health or substance abuse Program Area identification code into the 400 code in its CCS 3 submissions.

33. *How do you count training hours provided to peers who are employed in CSB services?*

    ANSWER: Taxonomy 7.1 identifies staff training as an indirect service (page 19), so it would not be counted in reporting units of services.

34. *Should substance abuse Prevention Services data be included in CCS 3 extracts?*

    ANSWER: No, all substance abuse Prevention Services must be submitted to the Department through the KITS Prevention System; no substance abuse Prevention Services data should be submitted through the CCS 3 extracts. See page 7 of the CCS 3 Extract Specifications. Substance abuse Prevention Services units of service data from the KITS Prevention System must be entered, manually or through flat file input from KITS, in the CARS 2nd and 4th quarter performance contract reports. The KITS Prevention System service unit data must not be adjusted or changed in the CARS reports. If CSB staff in a substance abuse program (e.g., Outpatient Services) that is not a substance abuse prevention program describes and seeks to report some of the services that they provide as substance abuse Prevention Services, those services must be entered in the KITS Prevention System and not reported in CCS 3, or those services must be categorized correctly as another substance abuse core service, not as substance abuse Prevention Services, and reported through CCS 3. Training on the KITS Prevention System is available on request from the Department's Office of Substance Abuse Services.

35. *Why was Substance Abuse Motivation Treatment in Taxonomy 7 changed to Motivational Treatment in Taxonomy 7.1? Is it still only a substance abuse service?*

    ANSWER: Substance Abuse Motivational Treatment Services was moved to Services Available Outside of a Program Area and renamed Motivational Treatment Services as a result of the adoption of the New CCS Admission and Discharge Paradigm. This service still includes the types of activities provided to consumers with substance use disorder diagnoses or co-occurring disorders. However, this service now also includes other activities, such as psycho-educational services provided to consumers with mental illness diagnoses or co-occurring disorders. Psycho-educational services are not included in Early Intervention Services, given the definition of Early Intervention Services, and the fact that psycho-education is an evidence-based practice in mental health services.

36. *Where are services to homeless persons supposed to be shown?*

    ANSWER: Services provided to individuals through Projects for Assistance in Transition from Homelessness (PATH) are included in Consumer Monitoring Services (390), which are in Services Available Outside of a Program Area. Individuals receiving PATH services must be assigned a Consumer Designation Code of 919. This would be entered on the TypeOfCare.txt file, even though normally consumers are not assigned Consumer Designation Codes without first being admitted to a Program Area. To date, this is the only exception to this business rule. See pages 6 and 7 of the CCS 3 Extract Specifications. If individuals who are homeless receive other services, such as Emergency, Outpatient, Day Support, or Residential Services, the CSB must admit those consumers to a Program Area (usually mental health or substance abuse) and report the services through CCS 3 in the usual manner.

37. *In our CSB, homeless services now include medical staff associated with them. The medical staff go out and evaluate homeless individuals, sometimes providing medications, and engage them like other clinicians in the shelter. Where should these services be shown?*

ANSWER: This activity should be included in Emergency Services; it seems to resemble the CSB's mobile crisis team closely. Clearly, this is not a Residential Service or a Consumer Monitoring Service, which includes PATH.

38. *In reporting provider service hours (CCS 3 data element 10), is client time to include only face-to-face hours? Can CSBs stop collecting and reporting client-related (consumer-related) time?*

ANSWER: Provider service hours are the hours available from all staff providing direct and consumer-related services, which are defined on pages 18 and 19 in Core Services Taxonomy 7.1. This has not changed from Taxonomy 7 and CCS 2. Therefore, CSBs must continue including consumer-related services and their related hours in the provider service hours they report to the Department. Consumer service hours are collected and reported only for Emergency, Motivational Treatment Consumer Monitoring, Outpatient, Opioid Detoxification, and Opioid Treatment Services. Consumer service hours measure the amounts of face-to-face (direct) services received by individual consumers. Consumer-related services and the related time are not included in consumer service hours, only direct, face-to-face hours are reported as consumer service hours. Refer to page 20 in Taxonomy 7.1.

39. *Shouldn't Ambulatory Crisis Stabilization be reported in FTEs instead of slots?*

ANSWER: The unit of service for Ambulatory Crisis Stabilization Services is day support hours, not provider service hours. Therefore, the capacity measure is not full-time-equivalents (FTEs) but day support slots. Ambulatory Crisis Stabilization Services was placed in the Day Support Services category because of its resemblance to Day Treatment/Partial Hospitalization.

40. *When the consumer is a child or adolescent, are services provided to the parent, family member, or guardian considered direct services, as defined on page 19 of Taxonomy 7.1?*

ANSWER: If the parent, family member, or guardian has not been opened as a case to the CSB or admitted to a Program Area, staff time spent serving these individuals is consumer-related services, since the identified consumer is the child or adolescent. In Taxonomy 7.1, and previous taxonomies, consumer-related hours are added to direct service hours and are reported as provider service hours.

41. *In the CCS 3 Service.txt file, what does year-to-date mean? Does the Service.txt file report services cumulatively throughout the fiscal year?*

ANSWER: The Service.txt file does not report services cumulatively throughout the fiscal year; that is, it does not add 30 units of service provided in the first month to an additional 30 units provided in the next month to make 60 units reported in the second month. The Service.txt file reports 30 units for the first month and 30 units for the second month in separate records. This is discussed more fully on page 11 of the CCS 3 Extract Specifications.

42. *Does a CSB have to submit a separate Services.txt record for each individual service unit provided to a consumer, even if multiple units of the same service are delivered by the same clinical or other services staff on the same day?*

ANSWER: This is a decision the CSB can make; it is part of the increased flexibility inherent in the CCS 3. If the same consumer receives multiple units of the same core service on the same day, these units can be aggregated into one Service.txt record. For example, if a consumer receives one hour of mental health Outpatient Services at 9:00 a.m., another hour at 11:00 a.m., and a third hour at 2:00 p.m., the CSB can aggregate the three hours and submit

them in one Service.txt record. This applies only to the same service provided to the same consumer on the same day. The same staff person or different staff people could provide the services, if the CSB does not use the optional StaffId field. If the CSB does use the optional StaffId field, the same staff person must provide the services in order for those services to be aggregated. These services are identified under the reporting category of Date Provided on page 7 and in the table on pages 8 and 9 of the CCS 3 Extract Specifications. Alternatively, the CSB could decide to submit three separate Service.txt records to report these services; either approach is acceptable.

The Service.txt file on page 17 of the CCS 3 Extract Specifications includes the ProgramAreaId as part of the file layout, and it also includes ServiceCode. Therefore, only service units with the same core service code (e.g., 310 for Outpatient Services) in the same Program Area (e.g., 100 for mental health services) could be aggregated on the same day.

43. *Can services of the same core service type (e.g., mental health Outpatient Services) delivered on the same day by different clinical or other services staff be aggregated in the Service.txt record?*

ANSWER: Yes**,** unless the CSB elects to provide the staff identification number (StaffId - data element 63) in the Service.txt record. Then, the CSB could only aggregate multiple units of the same core service in the same Program Area on the same day provided to the same consumer by the same staff person.

44. *Can the Units field be left blank in a Service.txt record?*

ANSWER: No, this field must always contain a number of units; otherwise, there would be no reason to submit the Service.txt record.

45. *What will be done with staff identification number data (CCS 3 StaffID - data element 63) if a CSB elects to submit this information as part of its Service.txt files?*

ANSWER: StaffID is the only optional CCS 3 data element. Reporting a local staff identification number as part of the Service.txt file will provide important information beyond individual CSB-level consumer data about the range, duration, and context of clinician and consumer contacts in services. The therapeutic alliance between the consumer and clinician is a key component to the achievement of some important positive outcomes, and reviews of caseload size and mix will help in interpreting program performance and outcome indicators. For evidence-based mental health practices, such as PACT and Supported Employment, clinician and consumer contact also serves as an element of monitoring fidelity with the evidence-based practice model.